ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Aging and Adult Administration

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

NAME OF INDIVIDUAL OR COMPANY **TO:**	TELEPHONE NO.

ADDRESS *(No., Street, City, State, ZIP)*

I,_____ authorize the release of any confidential information you may possess regarding my medical, social, and/or financial affairs, to the representative of the Arizona Long Term Care Ombudsman Program of the Arizona Department of Economic Security's Aging and Adult Administration, and _____ .

I understand that this information will not be further disclosed by the Ombudsman Program except as provided by law or court order.

SIGNATURE	DATE

For Verbal Consent Only

WITNESS' SIGNATURE	DATE